

PATIENT MEDICAL UPDATE

NAME: _____

DATE: _____

HOME PHONE: _____

WORK PHONE: _____

DOB: _____

CELL PHONE: _____

AGE: _____

List all medications you are presently taking including hormones or birth control pills:

List any allergies to medications you may have:

Form of contraception you are currently using:

_____ Hysterectomy _____ Ablation _____ Tubal Ligation _____ IUD
_____ Depo Provera _____ Birth Control Pill _____ Other _____

First day of last period: _____

Do you smoke Y/N

Surgery since last visit: Y/N _____

Have there been any changes in your family medical history? If yes, please explain:

Other pertinent medical issues or concerns:

Primary Care Physician Y/N If yes, please give name: _____